No. 84-495 (6)

IN THE

Supreme Court of the United States

OCTOBER TERM, 1984

RICHARD THORNBURGH, *et al.*,

Appellants,

v.

AMERICAN COLLEGE OF OBSTETRICIANS AND GYNECOLOGISTS, PENNSYLVANIA SECTION, *et al.*,

Appellees.

ON APPEAL FROM THE UNITED STATES COURT OF APPEALS FOR THE THIRD CIRCUIT

BRIEF AMICI CURIAE OF WATSON D. BOWES, JR., M.D. AND RICHARD T. S. SCHMIDT, M.D. IN SUPPORT OF APPELLANTS

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BRIEF AMICI CURIAE OF
WATSON D. BOWES, JR., M.D. AND
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INTEREST OF AMICI CURIAE

Amicus Watson A. Bowes, Jr., M.D., is a professor in the Department of Obstetrics and Gynecology, Division of Maternal and Fetal Medicine, at the University of North Carolina School of Medicine. (*See* Appendix for curriculum vitae.) Amicus Richard T. F. Schmidt, M.D., is Director of the Department of Obstetrics and Gynecology at Good Samaritan Hospital in Cincinnati, Ohio, and is former national president of the American College of Obstetricians and Gynecologists. (*See* Appendix for curriculum vitae.) Amici recognize the importance of recent advancements of modern medicine in the area of fetal viability, and the need for room for further developments in the care of unborn and premature children. Amici also recognize the need for the collection of basic

health data to assist the development of care for pregnant women and their children.

Amici have obtained written consent from the parties for the filing of this brief, and have filed the consent letters with the Clerk of this Court.

SUMMARY OF ARGUMENT

The court of appeals held unconstitutional certain abortion reporting requirements of Pennsylvania law. These provisions allow Pennsylvania to obtain basic information essential to the protection of viable unborn children and women undergoing abortions, and thus represent permissible abortion regulations.

One section (§ 3211(a)) requires the aborting physician to determine, in pregnancies beyond the first trimester, whether the child to be aborted is viable. If the physician concludes that the child is not viable, he must report the basis for that determination. This provision represents a valid expression of the compelling state interest in protecting viable unborn children. *See Planned Parenthood of Central Missouri v. Danforth,* 428 U.S. 52, 63-64 (1976).

The state has a compelling interest in the protection of viable unborn children. If this compelling interest is to have any meaning, the state must be able to identify, as a threshold matter, which unborn children are viable. The state may not, however, itself fix an arbitrary point of viability, but must instead rely upon the judgment of the physician. Hence, in order to effectuate its interest in protecting viable unborn children, the state may require the physician to make the determination of viability.

Pennsylvania has limited the requirement of a viability determination to abortions after the first trimester of pregnancy. The exclusion of abortions performed in the first trimester, though not constitutionally necessary (viability determination in the first trimester is, because medically trivial, constitutionally insignificant), exempts the vast majority of abortions of nonviable children, while allowing room for further expansions at the frontier of viability. (Viability

already extends back into the latter part of the second trimester.)

The viability determination and reporting law does not burden the abortion decision, since it merely requires the physician to consider factors (e.g., length of gestation, woman's general health) already relevant to sound abortion practice. Consequently the test of rational scrutiny applies, and this essential informational law easily passes constitutional muster.

The other reporting provision which the court of appeals struck down (§ 3214(a), (b), (e), (h)) requires the reporting of certain basic health data concerning abortions. This section permissibly furthers the important state interest in maternal health. *Planned Parenthood Association of Kansas City, Missouri, Inc. v. Ashcroft,* 462 U.S. 476, 486-90 (1983) (plurality opinion); *Planned Parenthood of Central Missouri v. Danforth,* 428 U.S. 52, 80-81 (1976).

The state has an important interest in safeguarding maternal health and medical standards in the area of abortion. Recordkeeping and reporting laws further the health concerns which underly the abortion right; consequently such regulation has no legal impact on this right, even when the regulation causes a small increase in the cost of abortion.

The Pennsylvania law allows the state to obtain routine, basic information relevant to the health supervision of abortion. The data categories largely incorporate national standards for health analysis, and thus both represent accepted epidemologic methods and assist the pursuit of national health objectives. Moreover, the information obtained contributes to the formation of the groundwork for judicial and legislative treatment of abortion and abortion regulations.

The Pennsylvania health reporting requirements do not burden the abortion right. These background health regulations have no legal impact on the abortion decision. Furthermore, a responsible aborting physician will already obtain such standard health data as part of sound abortion practice. Thus, the law merely sets forth standard bookkeeping requirements in the area of vital statistics. Consequently, the

test of rationality applies, and this straightforward health regulation survives constitutional review.

The abortion reporting laws before this Court fall well within constitutional limits, and advance threshold concerns crucial to the expression of state interests in abortion regulation. This Court should uphold the challenged provisions.

ARGUMENT

The Court of Appeals for the Third Circuit struck down as unconstitutional numerous sections of the 1982 Abortion Control Act of Pennsylvania, 18 Pa. Cons. Stat. Ann. §§ 3201-3220 (Purdon 1983). *American College of Obstetricians and Gynecologists, Pennsylvania Section v. Thornburgh,* 737 F.2d 283 (3rd Cir. 1984). Two of these sections, §§ 3211 and 3214, establish reporting requirements which permit Pennsylvania to obtain information essential to the safeguarding of state interests in the protection of unborn children and their mothers. The court of appeals effectively and improperly stifled these interests when it prohibited Pennsylvania from securing this information. This Court should therefore reverse the judgment of the court of appeals, and uphold §§ 3211 and 3214.

I.

THE REQUIREMENTS OF § 3211 VALIDLY EXPRESS THE COMPELLING INTEREST OF THE STATE IN PROTECTING VIABLE UNBORN CHILDREN.

Section 3211(a) of the Pennsylvania law provides as follows:

> Prior to performing any abortion upon a woman subsequent to her first trimester of pregnancy, the physician shall determine whether, in his good faith judgment, the child is viable. When a physician has determined that a child is viable, he shall report the basis for his determination that the abortion is necessary to preserve maternal life or health. When a physician has determined that a child is not viable, he shall report the basis for such determination.

18 Pa. Cons. Stat. Ann. § 3211(a) (Purdon 1983).

This provision validly furthers the compelling state interest in the life of viable children in the womb; hence, this Court should reverse the decision of the court of appeals and uphold § 3211(a).

A. The State Has a Compelling Interest in the Protection of Viable Unborn Children.

A state has an important and legitimate interest in protecting unborn children. *City of Akron v. Akron Center for Reproductive Health, Inc.,* 462 U.S. 416, 428 (1983). This interest exists throughout pregnancy, *id.,* and becomes compelling when the child attains viability, *id.*

B. The Compelling State Interest in the Life of Viable Unborn Children Supports § 3211.

The compelling state interest in the protection of viable children in the womb supports the requirements of § 3211.

The state interest in viable children would be meaningless if the state could not require the physician to determine whether the child intended for abortion was viable. A state may not proclaim some fixed point in gestation or fetal development to be the point of viability. *Colautti v. Franklin,* 439 U.S. 379, 388-89 (1979); *Planned Parenthood of Central Missouri v. Danforth,* 428 U.S. 52, 64-65 (1976). Legal establishment of such an arbitrary point of viability would be neither constitutionally permissible, *Colautti; Danforth,* nor biologically sound, *Colautti,* 439 U.S. at 395-96. Consequently, the state must rely upon the medical judgment of the responsible physician. *Id.* at 388; *Danforth,* 428 U.S. at 64-65.

At a minimum, then, the state may require the physician whose medical judgment the state relies upon to exercise that judgment and determine whether the child slated for abortion is viable. *See Danforth,* 428 U.S. at 89 (concurring

opinion of Stewart, J., joined by Powell, J.) (upholding challenged definition of viability) ("The State has merely required physicians performing abortions to *certify* that the fetus to be aborted is not viable") (emphasis in original). To enforce this requirement, the state may then require the physician to report the basis for his judgment. *See id.*[1]

The question of viability constitutes a threshold inquiry essential to any regulation of post-viable abortions. Consequently, a state may require a determination of viability for all abortions performed. For those pregnancies for which early gestation currently precludes viability, the inquiry is simple. The determination that the pregnancy has not progressed beyond the first trimester, for example—a determination made as a matter of course—would effectively constitute a determination of nonviability. To report the basis for the determination of nonviability, then, the physician would need only to note that the woman was still at an early stage of gestation.

When the pregnancy has progressed to a point at which viability becomes a realistic possibility, the medical determination becomes somewhat more involved. The relevant state interest, however, becomes correspondingly stronger, as the importance of the viability determination grows. In early pregnancies, the physician's task is trivial, and an important state interest justifies the regulation. In later pregnancies, the medical task is greater, but a compelling state interest justifies the regulation.

Pennsylvania, therefore, could constitutionally have required a determination of viability, and a reporting of the

[1] In *Danforth*, this Court considered parts of a statutory scheme which required, in one provision, that the physician certify the nonviability of any child aborted for reasons other than to preserve the life or health of the mother. While that particular provision was not presented for review, the Court noted in upholding a related section that the provision "reflects an attempt . . . to comply with our observations and discussion in *Roe* [*v. Wade*, 410 U.S. 113 (1973)] relating to viability." 428 U.S. at 63-64.

basis for this determination, for all abortions.[2] The state has not gone so far, however. Instead, it has limited the need for a viability determination to those abortions performed after the first trimester, *see* § 3211(a), and has only required the physician to report the basis of the determination when the physician finds the child not to be viable, *see id.* Thus, § 3211(a) is more narrowly tailored than is necessary, and easily satisfies constitutional requirements.

By limiting the viability determination and reporting requirement to abortions performed after the first trimester, Pennsylvania has spared physicians a minor adminstrative task in the vast majority of abortions,[3] while allowing room for scientific advancement in the area of viability. When this Court decided *Roe v. Wade*, 410 U.S. 113 (1973), the Court noted that viability "is usually placed at about seven months (28 weeks), but may occur earlier, even at 24 weeks." 410 U.S. at 160 (footnote omitted). By the time of the Court's decision in *City of Akron v. Akron Center for Reproductive Health, Inc.*, 462 U.S. 416 (1983), the frontier of viability had already extended to 22 weeks of gestation. *Id.* at 457 n.5 (O'Connor, J., dissenting). *See also* Dunn & Stirrat, *Capable of Being Born Alive?*, 1 The Lancet 553, 554 (1984) (World Health Organization (WHO) recommendations urge that perinatal statistics include children of 22 weeks gestation or more). At the time of *Roe*, a fetal weight of 1000g represented the general lower cutoff for viability. 462 U.S. at 457 (O'Connor, J., dissenting). By the time of *Akron*, the general cutoff had dropped to 500g. *Id.* at 457 n.5; Dunn & Stirrat, *supra*, at 554 (WHO guidelines set 500g as lower limit). *See also* Pleasure, Dhand & Kaur, *What Is the Lower Limit of*

[2] No difference of constitutional dimension exists between requiring the physician facing a first trimester pregnancy to report—under an all-inclusive statute—that viability cannot exist, or to note—under the Pennsylvania scheme—that the reporting statute does not apply.

[3] For the last five years for which official national statistics are available, at least 90% of all abortions took place during the first trimester. Centers for Disease Control, *Abortion Surveillance, 1981*, in 33 CDC Surveillance Summaries 1SS, 3SS (No. 3SS, 1984).

Viability?, 138 Am. J. Diseases Children 783 (1984) (describing healthy outcome, after two years, of child weighing 440g at delivery).

This trend of expanding viability has already pushed the lower limits of viability back into the second trimester of pregnancy. As technology advances, the capacity for extrauterine survival will reach children of even earlier gestational stages. The Pennsylvania law, by requiring determinations of viability in the second trimester as well as the third, has recognized recent developments in the care of premature infants, and has allowed proper flexibility "for anticipated advancements in medical skill." *Colautti*, 439 U.S. at 387.[4]

Section 3211 does not burden the abortion decision.[5] It merely requires the physician to do that which sound medical practice already would dictate—primarily, obtain an estimate of gestational age and fetal size.[6] These two factors influence the choice of abortion method, *see* Centers for Dis-

[4] These "anticipated advancements" represent the leading edge of medical science; hence state lawmakers cannot predict with precision the date or the extent of future breakthroughs. The Constitution, however, allows the state the latitude necessary to legislate in this area, and does not force the state to amend its laws with each incremental extension of the viability frontier. *Cf. Planned Parenthood Association of Kansas City, Missouri, Inc. v. Ashcroft*, 462 U.S. 476, 483 n.7, 485-86 (1983) (plurality opinion) (upholding requirement of second physician for abortion of viable children, despite uncertainty of child's survival).

[5] Since a compelling interest supports the regulation of post-viability abortions, § 3211 would survive constitutional scrutiny even if it burdened the abortion right: the threshold determination of viability obviously constitutes an essential prerequisite to any expression of this state interest, and thus is both reasonably related to and narrowly drawn to further this compelling interest.

[6] Other factors possibly relevant to the viability question, *see Colautti*, 439 U.S. at 395-96 (woman's general health and nutrition, quality of available medical facilities), like gestational age and fetal size, represent information essential to the proper performance of abortions; hence the acquisition of such information to determine viability entails no new burden for the physician.

ease Control, *Abortion Surveillance 1979-1980* 6 (1983), and thus inquiry into these factors forms a routine prelude to abortion. Gestation and fetal size, in turn, correspond roughly with fetal weight, Kloosterman, *Birthweight and Maturity*, in 1972 *WHO Public Health Papers* 38 (no. 42); Chervenak, Jeanty & Hobbins, *Current Status of Fetal Age and Growth Assessment*, 10 Clinics Obstet. & Gynecol. 423 (1983), which is the principal indicator of viability, Hutchins, Kessel & Placek, *Trends in Maternal and Infant Health Factors Associated with Low Infant Birth Weight, United States, 1972 and 1980*, 99 Pub. Health Rep. 162, 162 (1984); Sepkowitz, *An Appraisal of Neonatal Intensive Care Unit Weight-Specific Mortality Rates*, 76 J. Okla. St. Med. A. 339, 342 (1983). Requiring the physician to take the extra mental step of formulating a conclusion about viability and—if the conclusion is against viability—reporting the basis for this determination, does not burden the abortion decision, and may even promote maternal health by inducing the physician to scrutinize more closely the state of the pregnancy.

Since § 3211 does not burden the woman's decision to abort, the test of rational scrutiny applies. *Maher v. Roe*, 432 U.S. 464, 478 (1977). As a threshold matter essential to the effectuation of state protection for viable unborn children, the requirements of a viability determination and the reporting of the basis for that determination clearly pass the test of rationality.

Section 3211, then, represents a permissible expression of the compelling state interest in the protection of viable unborn children. The judgment of the court of appeals, which invalidated § 3211(a), should be reversed.

II.

THE REQUIREMENTS OF § 3214 VALIDLY EXPRESS THE IMPORTANT INTEREST OF THE STATE IN PROTECTING MATERNAL HEALTH.

Section 3214 provides, in subsections (a), (b), (e), and (h), for the reporting of certain information relevant to the performance of abortions. The court of appeals invalidated

these subsections. (*See* Appendix for text of subsections.)

These provisions validly implement the interest of Pennsylvania in furthering maternal health.[7] Hence, this Court should reverse the decision of the court of appeals and uphold § 3214.

A. The State Has an Important Interest in the Preservation of Maternal Health.

A state has an important and legitimate interest in safeguarding maternal health and maintaining medical standards in the area of abortion. *Akron,* 462 U.S. at 428-29. This interest exists throughout pregnancy, and becomes compelling at approximately the end of the first trimester. *Id.* at 429. The state may enact regulations that apply to all stages of pregnancy when those regulations "have no significant impact on the woman's exercise of her right" and further "important state health objectives." *Id.* at 430.

B. The Important State Interest in Maternal Health Supports § 3214.

Recordkeeping and reporting laws which promote maternal health constitute permissible expressions of the important state interest in maternal health. *Danforth,* 428 U.S. at 80-81 (general authorization of recordkeeping and reporting); *Planned Parenthood Association of Kansas City, Missouri, Inc. v. Ashcroft,* 462 U.S. 476, 486-90 (1983) (plurality opinion) (pathology reports). Such recordkeeping furthers

[7] Health concerns support the recordkeeping and reporting provisions of § 3214(a)(1) to (7), (12), (14), and § 3214(b), (e), (h). The provisions of § 3214(a)(8) to (11), (13), merely represent mechanisms for enforcement of other sections of the abortion law. Subsections (8), (10), (11), and (13) expressly refer to other parts of the Pennsylvania law, and enable the state to assure compliance with the law. Subsection (9), requiring a report of the "length and weight of the unborn child when measurable," facilitiates enforcement of the provisions relating to viability, since fetal weight is a main indicator of both gestational age and viability. Sepkowitz, *supra* p. 9, at 342. These subsections therefore constitute permissible corollaries to other valid abortion regulations.

the health concerns which form a predicate for the abortion right, *Connecticut v. Menillo,* 423 U.S. 9, 11 (1975) (per curiam); *see also Harris v. McRae,* 448 U.S. 297, 316 (1980) (woman's health may be core concern supporting abortion liberty). The abortion right presupposes the existence of such regulation, or its equivalent. Consequently, these reporting requirements do not have a "legally significant impact or consequence on the abortion decision," *Danforth,* 428 U.S. at 81; *Menillo,* 423 U.S. at 11. Even when the regulations produce a small increase in the cost of abortions, the resulting burden is "relatively insignificant" and constitutionally permissible. *Ashcroft,* 462 U.S. at 490 (plurality opinion) ($19.40 estimated additional cost per abortion).

Through the provisions of § 3214, Pennsylvania has sought to obtain basic information relevant to the supervision of the health aspects of abortion. The data requested represent standard demographic and medical factors employed in health analyses, form an essential informational basis for medical and legal developments in the area of abortion, and create no serious burdens for the aborting physician.

1. The categories of data incorporate standard demographic and medical factors.

The categories of information sought under § 3214 correspond closely with the type of data which the Centers for Disease Control (CDC), a division of the United States Department of Health and Human Services, uses for its official national supervision of abortion.[8] *Compare* Centers for Dis-

[8] *See* Centers for Disease Control, *Abortion Surveillance 1979-1980* (1983) (preface):

> Recognizing both the importance of abortion as a public health issue and the need for national abortion statistics, the Division of Reproductive Health [a part of CDC] . . . in 1969 began continuous epidemiologic surveillance of abortion in the United States. The objectives of this surveillance are twofold: 1) to document the number and characteristics of women obtaining abortions, and 2) to eliminate preventable mortality and morbidity related to abortion.

ease Control, *Abortion Surveillance 1979-1980* 4-6, 8, 13, 15 (1983) [hereinafter cited as CDC], *with* § 3214(a)(2) (residence status), 3214(a)(3) (age, race, marital status), 3214(a)(4) (prior pregnancies), 3214(a)(5) (gestational age), 3214(a)(6) (type of procedure), 3214(a)(7) (complications), 3214(a)(14) (source of funds for abortion). The Pennsylvania law, in essence, merely adopts the national standards for abortion surveillance. The law therefore facilitates national statistical analysis, by assuring the availability of the data, *see* CDC, *supra,* at 3 (noting varying availability of demographic information from different states), and incorporates accepted means of health review.

2. The information collected forms an essential basis for medical and legal treatment of abortion.

The data provided under § 3214 supplies the basis for informed medical and legal consideration of abortion.

As a medical matter, the collection of health statistics enables the sort of broad perspective necessary for new developments within the field. The CDC, as discussed above, collects abortion information virtually identical to that required under § 3214, to help "eliminate preventable mortality and morbidity related to abortion." CDC, *supra* (preface). *See also Ashcroft,* 462 U.S. at 487-88 (plurality opinion) ("questions remain as to the long-range complications [of abortion] and their effect on subsequent pregnancies") (citations omitted); *Danforth,* 428 U.S. at 81 (recordkeeping "may be a resource that is relevant to decisions involving medical experience and judgment") (footnote omitted).

This Court has repeatedly emphasized the importance of medical judgment to the abortion decision and its effectuation. *Akron,* 462 U.S. at 427, 448, 450; *H.L. v. Matheson,* 450 U.S. 398, 419 (1981); *Colautti v. Franklin,* 439 U.S. 379, 387 (1979); *Doe v. Bolton,* 410 U.S. 179, 192 (1973); *Roe v. Wade,* 410 U.S. 113, 163, 165-66 (1973). The collection and analysis of health statistics relevant to abortion helps facilitate the ideal of the "competent, conscientious, and ethical physician." *Akron,* 462 U.S. at 448 n.39 (citation omitted).

As a legal matter, health statistics form much of the basis for judicial and legislative decisions. This Court has repeatedly relied upon medical statistics in its shaping of abortion jurisprudence. *E.g., Roe v. Wade,* 410 U.S. at 163 (state interest in maternal health becomes compelling at end of first trimester "because of the now-established medical fact . . . that until the end of the first trimester mortality in abortion may be less than mortality in childbirth"); *Danforth,* 428 U.S. at 77-79 (prohibition on saline amniocentesis unconstitutional because is method which is "most commonly used nationally by physicians after the first trimester and which is safer, with respect to maternal mortality, than . . . normal childbirth"); *Akron,* 462 U.S. at 437-39 (second-trimester hospitalization requirement unconstitutional because "dilation-and-evacuation" method may be used safely on outpatient basis in early weeks of second trimester). In its recent *Akron* decision the Court emphasized the relevance of "accepted medical practice" to the evaluation of abortion regulation. 462 U.S. at 431, 434. The information sought under § 3214 facilitates both the description and the development of accepted medical practice.

Legislative and administrative bodies, furthermore, need information such as that which § 3214 would provide, in order to regulate in the area of abortion. This valuable health data would serve both to aid compliance with the pronouncements of this Court, and to identify problems in need of remedial legislation. Without such information, these governing bodies could only act blindly; the judiciary, meanwhile, would be unable to evaluate the reasonableness of such regulation.

3. The reporting requirements impose no impermissible burdens on the performance of abortions.

The requirements of § 3214 place no impermissible burdens upon the abortion decision or its effectuation. Reporting requirements which further maternal health do not infringe upon the abortion liberty. *Ashcroft,* 462 U.S. at 489-90 (plurality opinion); *Danforth,* 428 U.S. at 81; *Menillo,* 423 U.S. at 11. The Pennsylvania provision requests information

which is readily available from the woman or her physician, and much of which will be necessary in any event as a matter of sound medical practice (e.g., length of gestation, age of woman). Since the data sought in § 3214 largely reflect categories of information already collected in much of the country, *see* CDC, *supra* p.11, § 3214 imposes no more than standard bookkeeping requirements in the area of vital statistics.

The requirements of § 3214 represent valuable implementations of the state interests in protecting maternal health. This Court should therefore reverse the judgment of the court of appeals, which invalidated several provisions of this section.

CONCLUSION

In §§ 3211 and 3214, Pennsylvania has sought to obtain basic information necessary to the implementation of its interests in the protection of viable unborn children and the preservation of maternal health. Since they place no burdens on the abortion right, the test of rationality applies. This standard collection of vital abortion data clearly furthers state health concerns, and thus passes constitutional muster. The judgment of the court of appeals denies the state access to this basic information, and frustrates valid state regulation. This Court should now reverse the judgment of the court of appeals, and uphold the constitutionality of §§ 3211 and 3214.

Respectfully submitted,

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APPENDIX

1. Text of Reporting Laws Overturned by Court of Appeals

§ 3211(a) Determination of viability.—Prior to performing any abortion upon a woman subsequent to her first trimester of pregnancy, the physician shall determine whether, in his good faith judgment, the child is viable. When a physician has determined that a child is viable, he shall report the basis for his determination that the abortion is necessary to preserve maternal life or health. When a physician has determined that a child is not viable, he shall report the basis for such determination.

§ 3214(a) General rule.—A report of each abortion performed shall be made to the department on forms prescribed by it. The report forms shall not identify the individual patient by name and shall include the following information:

(1) Identification of the physician who performed the abortion and the facility where the abortion was performed and of the referring physician, agency or service, if any.

(2) The political subdivision and state in which the woman resides.

(3) The woman's age, race and marital status.

(4) The number of prior pregnancies.

(5) The date of the woman's last menstrual period and the probable gestational age of the unborn child.

(6) The type of procedure performed or prescribed and the date of the abortion.

(7) Complications, if any, including but not limited to, rubella disease, hydatid mole, endocervical polyp and malignancies.

(8) The information required to be reported under section 3211(a) (relating to viability).

(9) The length and weight of the aborted unborn child when measurable.

(10) Basis for any medical judgment that a medical emergency existed as required by any part of this chapter.

(11) The date of the medical consultation required by section 3204(b) (relating to medical consultation and judgment).

(12) The date on which any determination of pregnancy was made.

(13) The information required to be reported under section 3210(b) (relating to abortion after viability).

(14) Whether the abortion was paid for by the patient, by medical assistance, or by medical insurance coverage.

(b) Completion of report.—The reports shall be completed by the hospital or other licensed facility, signed by the physician who performed the abortion and transmitted to the department within 15 days after each reporting month.

* * *

(e) Statistical reports; public-availability of reports.—

(1) The department shall prepare an annual statistical report for the General Assembly based upon the data gathered under subsection (a). Such report shall not lead to the disclosure of the identity of any person filing a report or about whom a report is filed, and shall be available for public inspection and copying.

(2) Reports filed pursuant to subsection (a) shall not be deemed public records within the meaning of that term as defined by the act of June 21, 1957 (P.L. 390, No. 212), referred to as the Right-to-Know Law, but shall be made available for public inspection and copying within 15 days of receipt in a form which will not lead to the disclosure of the identity of any person filing a report. On those reports available for public inspection and copying, the department shall substitute for the name of any physician which appears on the report, a unique identifying number. The identity of the physician shall constitute a confidential

record of the department. The department may set a reasonable per copy fee to cover the cost of making any copies authorized hereunder.

(3) Original copies of all reports filed under subsection (a) shall be available to the State Board of Medical Education and Licensure, and to law enforcement officials, for use in the performance of their official duties.

(4) Any person who willfully discloses any information obtained from reports filed pursuant to subsection (a), other than that disclosure authorized under paragraph (1), (2) or (3) hereof or as otherwise authorized by law, shall commit a misdemeanor of the third degree.

* * *

(h) Report of complications.—Every physician who is called upon to provide medical care or treatment to a woman who is in need of medical care because of a complication or complications resulting, in the good faith judgment of the physician, from having undergone an abortion or attempted abortion shall prepare a report thereof and file the report with the department within 30 days of the date of his first examination of the woman, which report shall be open to public inspection and copying and shall be on forms prescribed by the department, which forms shall contain the following information, as recieved, and such other information except the name of the patient as the department may from time to time require:

(1) Age of patient.

(2) Number of pregnancies patient may have had prior to the abortion.

(3) Number and type of abortions patient may have had prior to this abortion.

(4) Name and address of the facility where the abortion was performed.

(5) Gestational age of the unborn child at the time of the abortion, if known.

(6) Type of abortion performed, if known.

(7) Nature of complication or complications.
(8) Medical treatment given.
(9) The nature and extent, if known, of any permanent condition caused by the complication.

18 Pa. Cons. Stat. Ann. §§ 3211, 3214 (Purdon 1983).

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Alpha Omega Alpha

Professional Societies:

1. American Association of Pro Life Obstetricians and Gynecologists
2. American College of Obstetricians and Gynecologists
3. American Gynecological and Obstetrical Society
4. Robert A. Ross Obstetrical and Gynecological Society
5. Society of Perinatal Obstetricians

Articles:

1. Bowes, Jr., *The Knight of Norwich (Sir Thomas Browne),* 57 Rocky Mtn. Med. J. 57 (1960).
2. Bruns, Bowes, Jr., Drose & Battaglia, *Effect of Respiratory Acidosis on the Rabbit Fetus in Utero,* 87 Am. J. Obstet. & Gynecol. 1074 (1963).
3. Bowes, Jr., Drose & Bruns, *Amniocentesis and Intrauterine Fetal Transfusion in Erythroblastosis,* 93 Am. J. Obstet. & Gynecol. 822 (1965).
4. Brazie, Ibbott & Bowes, Jr., *Identification of the Pigment in Amniotic Fluid of Erythroblastosis as Bilirubin,* 69 J. Pediatrics 354 (1966).
5. Battaglia, Meschia, Makowski & Bowes, Jr., *The Effect of Maternal Oxygen Inhalation upon Fetal Oxygenation,* 47 J. Clinical Investigation 548 (1968).
6. Bowes, Jr. & Droegemueller, *Intrauterine Transfusion of Twins,* 108 Cal. Med. 380 (1968).
7. Brazie, Bowes, Jr. & Ibbott, *An Improved Rapid Procedure for the Determination of Amniotic Fluid Bilirubin and its Use in the Prediction of the Course of Rh Sensitized Pregnancies,* 104 Am. J. Obstet. & Gynecol. 80 (1969).
8. Battaglia, Bowes, Jr., McGaughey, Makowski & Meschia, *The Effect of Fetal Exchange Transfusions with Adult Blood Upon Fetal Oxygenation,* 3 Pediatric Research 60 (1969).

9. Bowes, Jr., Gibson, Beibovitz & Palin, *Rubella Antibody Screening in a Prenatal Clinic Using the Indirect Fluorescent Antibody Test,* 35 Obstet. & Gynecol. 7 (1970).
10. Bowes, Jr., Brackbill, Conway & Steinschneider, *The Effects of Obstetrical Medication of Fetus and Infant,* 35 Monographs Soc. for Research Child Dev. (No. 4, 1970).
11. Sabol, Gibson & Bowes, Jr., *Pitressin Injection in Cervical Conization: A Double-Blind Controlled Study,* 37 Obstet. & Gynecol. 596 (1971).
12. Haverkamp & Bowes, Jr., *Uterine Perforation: A Complication of Continuous Fetal Monitoring,* 110 Am. J. Obstet. & Gynecol. 667 (1971).
13. Bowes, Jr., *Intrauterine Transfusion Indication and Results,* 14 Clinical Obstet. & Gynecol. 561 (1971).
14. Robinson, Bowes, Jr. & Droegemueller, *Intrauterine Diagnosis: Potential Complications,* 116 Am. J. Obstet. & Gynecol. 937 (1973).
15. Barton & Bowes, Jr., *Successful Pregnancy in a Patient with Severe Superior Vena Cava Syndrome,* 65 Chest 2 (1974).
16. Jeffrey, Bowes, Jr. & Delaney, *Role of Bed Rest in Twin Gestation,* 43 Obstet. & Gynecol. 822 (1974).
17. Kohler, Dubois, Merrill & Bowes, Jr., *Prevention of Chronic Neonatal Hepatitis B Virus Infection with Antibody to the Hepatitis B Surface Antigen,* 291 New Eng. J. Med. 1253 (1975).
18. Jones, Burd, Bowes, Jr., Battaglia & Lubchenco, *Failure of Association of Premature Rupture of Membranes with Respiratory-Distress Syndrome,* 292 New Eng. J. Med. 1253 (1975).
19. Kuhn, Duncan & Bowes, Jr., *Spontaneous Opening of Congenital Imperforate Hymen,* 87 J. Pediatrics 768 (1975).
20. Bowes, Jr., *Detection and Treatment of Tuberculosis,* 6 Contemp. Ob/Gyn 43 (1975).

21. Kowalski & Bowes, Jr., *Parent's Response to a Stillborn Baby,* 8 Contemp. Ob/Gyn 53 (1976).
22. Carson, Losey, Bowes, Jr. & Simmons, *Combined Obstetric and Pediatric Approach to Prevent Meconium Aspiration Syndrome,* 126 Am. J. Obstet. & Gynecol. 712 (1976).
23. Kowalski, Gottschalk, Greer & Bowes, Jr., *Team Nursing Coverage of Prenatal-Intrapartum Patients at a University Hospital: An Innovation in Obstetric Nursing,* 50 Obstet. & Gynecol. 116 (1977).
24. Bowes, Jr., *Results of the Intensive Perinatal Management of Very-Low-Birth-Weight Infants (501-1500),* in *Pre-Term Labour* 331 (A. Anderson, R. Beard, J. Brundenell & P. Dunn eds. 1977).
25. Carson, Simmons & Bowes, Jr., *Meconium Aspiration Syndrome Following Cesarean Section,* 130 Am. J. Obstet. & Gynecol. 596 (1978).
26. Bowes, Jr., Halgrimson & Simmons, *Results of the Intensive Perinatal Management of Very-Low-Birth-Weight Infants (501-1500 gm),* 23 J. Reproductive Med. 245 (1979).
27. Bowes, Jr., Taylor, O'Brien & Bowes, *Breech Delivery: Evaluation of the Method of Delivery on Perinatal Results and Maternal Morbidity,* 135 Am. J. Obstet. & Gynecol. 965 (1979).
28. Watson, Besch & Bowes, Jr., *Managment of Acute and Subacute Puerperal Inversion of the Uterus: A Case Controlled Study,* 55 Obstet. & Gynecol. 12 (1980).
29. Bowes, Jr., *Current Role of the Midforceps Operation,* 23 Clinical Obstet. & Gynecol. 549 (1980).
30. Bowes, Jr., *The Puerperium,* 23 Clinical Obstet. & Gynecol. (No. 4, W. Bowes, Jr. ed. 1980).
31. Bowes, Jr., Gabbe & Bowes, *Fetal Heart Monitoring in Premature Infants Weighing 1500 Grams or Less,* 22 Am. J. Obstet. & Gynecol. 549 (1980).
32. Bowes, Jr., *The Effect of Medications on the Lactating Mother and Her Infants,* 23 Clinical Obstet. & Gynecol. 1073 (1980).

33. Clewell, Dunne, Johnson & Bowes, Jr., *Fetal Transfusion with Real-Time Ultrasound Guidance,* 57 Obstet. & Gynecol. 516 (1981).
34. Bowes, Jr., *Delivery of the Very-Low-Birth-Weight Infant,* 8 Clinics Perinatology (No. 1, 1981).
35. Bowes, Jr. & Selgestad, *A Case of Fetal vs. Maternal Rights - The Modern Obstetrical Dilemma,* 58 Obstet. & Gynecol. 209 (1981).
36. Harvey & Bowes, Jr., *Maternal-Fetal Transport: Reflections on Experience at the University of Colorado Medical Center,* Perinatology-Neonatology 53 (Nov.-Dec. 1981).
37. Bowes, Jr., *Steps to Prevent Meconium Aspiration Syndrome,* 19 Contemp. Ob/Gyn 135 (1982).
38. Bowes, Jr., *A Review of Perinatal Mortality in Colorado, 1971-1978, and Its Relationship to the Regionalization of Perinatal Services,* 141 Am. J. Obstet. & Gynecol. 1045 (1981).
39. Clewell, Johnson, Meier, Newkirk, Zide, Hendee, Bowes, Jr., Hecht, O'Keefe, Henry & Shikes, *A Surgical Approach to the Treatment of Fetal Hydrocephalus,* 306 New Eng. J. Med. 1320 (1982).
40. Quirk, Jr. & Bowes, Jr., *Intrapartum Monitoring and Management of Low Birth Weight Fetus,* 9 Clinics Perinatology 363 (1982).
41. Fryer, Jr. & Bowes, Jr., *Factors Attracting Physicians to Rural Underserved Communities: The Case of Colorado,* 57 J. Med. Educ. 716 (1982).
42. Moore, Hershey, Johnigen & Bowes, Jr., *The Incidence of Pregnancy-Induced Hypertension Is Increased Among Colorado Residents of High Altitude,* 144 Am. J. Obstet. & Gynecol. 423 (1982).
43. Fryer, Jr. & Bowes, Jr., *In-State Experiences of Physicians Serving Rural Underserved Communities: The Case of Colorado,* 57 J. Med. Educ. 716 (1982).
44. Meier & Bowes, Jr., *Amniotic Fluid Embolus Like Syndrome Presenting in the Second Trimester of Pregnancy,* 61 Obstet. & Gynecol. 315 (1983).

45. Bowes, Jr., *Preventing Preterm Birth in the High-Risk Patient,* 8 Drug Therapy 33 (1983).
46. Bowes, Jr. & Fryer, Jr., *Rural Physicians and Continuing Education Programming,* 80 Colo. Med. (Mar. 1983).
47. Bowes, Jr., Fryer, Jr. & Ellis, *The Use of Standardized Neonatal Mortality Ratios to Assess the Quality of Perinatal Care in Colorado,* 148 Am. J. Obstet. & Gynecol. 1067 (1984).
48. Seeds, Cefalo, Herbert & Bowes, Jr., *Hydramnios and Maternal Renal Failure: Relief with Fetal Therapy,* 61 Obstet. & Gynecol. 265 (1984).
49. Seeds, Cefalo & Bowes, Jr., *Femur Length in the Estimation of Fetal Weight Less than 1500 Grams,* 149 Am. J. Obstet. & Gynecol. 233 (1984).
50. Seeds, Herbert, Bowes, Jr. & Cefalo, *Recurrent Idiopathic Fetal Hydrops: Results of Prenatal Therapy,* 64 Obstet. & Gynecol. 305 (1984).
51. Herbert, Seeds, Cefalo & Bowes, Jr., *Prenatal Detection of Intraamniotic Bands: Implications and Management,* Obstet. & Gynecol. (forthcoming).

Chapters in Books:

1. Droegemueller & Bowes, Jr., *Thrombophlebitis,* in *Current Therapy* (H. Conn ed. 1968).
2. Bowes, Jr., *The Placenta,* in *Care of the Well Baby* (K. Shepard ed. 1968).
3. Bowes, Jr. & Droegemueller, *Female Genitourinary System and Obstetrics,* in *Outpatient Surgery* ch. 20 (G. Hill ed. 1973).
4. Bowes, Jr. & Droegemueller, *Identification and Management of Intrauterine Growth Retardation,* in *Controversy in Obstetrics and Gynecology II* 10 (D. Reid & C. Christian eds. 1974).
5. Droegemueller & Bowes, Jr., *Thrombophlebitis,* in *Current Therapy* (H. Conn ed. 1974).

6. Jaffe, Schruefer, Bowes, Jr., Creasy, Sweet & Laros, Jr., *High Risk Pregnancies: Maternal Medical Disorders*, in 3 *Prevention of Embryonic, Fetal and Perinatal Disease* 27 (R. Brent & M. Harris eds. 1976) (DHEW Publication No. (NIH) 76-853).

7. Sever, Fuccillo & Bowes, Jr., *Environmental Factors: Infection and Immunizations*, in 3 *Prevention of Embryonic, Fetal and Perinatal Disease* 199 (R. Brent & M. Harris eds. 1976) (DHEW Publication No. (NIH) 76-853).

8. Robie & Bowes, Jr., *Immediate Resuscitation of the Newborn Infant*, in *Current Therapy in Obstetrics and Gynecology* 77 (E. Quilligan ed. 1980).

9. Bowes, Jr., *Obstetrical Emergencies*, in *Emergency Care* ch. 11 (J. Boswick, Jr. ed. 1981).

10. Bowes, Jr., *Pancreatitis*, in *Current Therapy in Obstetrics and Gynecology* (E. Quilligan ed. 1982).

11. Bowes, Jr., *Biochemical Testing-Estriols and Medical-Surgical Problems-Tuberculosis*, in *High Risk Pregnancy Protocols* (J. Queenan & J. Hobbins eds. 1982).

12. Bowes, Jr., *Intensive Obstetric Management of the Very-Low-Birth-Weight Infant*, in *Reid's Controversy in Obstetrics and Gynecology - III* (F. Zuspan & C. Christian eds. 1983).

13. Peterson & Bowes, Jr., *Drugs, Toxins and Environmental Agents in Breast Milk*, in *Lactation: Physiology, Nutrition and Breast-Feeding* (M. Neville & M. Neifert eds. 1983).

14. Bowes, Jr. & Watson, *Inversion of the Uterus*, in *Operative Perinatology, Invasive Obstetric Techniques* (L. Iffy & D. Charles eds. 1984).

15. Bowes, Jr., *Intensive Obstetrical Management of the Very-Low-Birth-Weight Infant*, in *Controversy in Obstetrics and Gynecology* (F. Zuspan & C. Christian eds., forthcoming).

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3. Curriculum Vitae: Richard T. F. Schmidt

Vital Statistics:

Born Sept. 23, 1918, Cincinnati, Ohio, of John J. and Elsa Wenning Schmidt

Married: Margaret Manchester 6-3-48

Children: Kristin Keye, 1950
Gregory John, 1952
Stephen Bruhl, 1956
John Joseph II, 1960

Education:

St. Xavier High School, graduated (first honors) 1936

Xavier University, B.S. cum laude 1940

Alpha Sigma Nu (national Jesuit college honorary society)

University of Cincinnati, M.D. Dec. 1943

Postgraduate Training:

Internship - University Hospitals of Cleveland (straight Ob-Gyn) 1944

Residency - University Hospitals of Cleveland, 1944-46 and 1948-49

Fellowship - Western Reserve University (teaching and Ob-Gyn liaison for major curriculum change) 1949-50

Military Service:

Army of the United States 1946-48

Chief, Womens' Division, Halloran General Hospital

Chief, Ob-Gyn Service, 183rd General Hospital

Specialty Board:

American Board of Obstetrics and Gynecology, certified 1953

Academic Appointments:

Demonstrator in Obstetrics and Gynecology, Western Reserve University, 1948-50

Instructor, Gynecology, University of Cincinnati, 1951-62

Assistant Clinical Professor, Gynecology, ibid., 1962-68
Assistant Clinical Professor, Obstetrics and Gynecology, 1968-71
Associate Clinical Professor, Obstetrics and Gynecology, 1971-75
Clinical Professor, Obstetrics and Gynecology, 1975—

Hospital Appointments:
Cincinnati General Hospital
Clinician, Gyn OPD, 1951—
Chief Clinician, Gyn OPD, 1965-69
Attending Gynecologist, 1962—
Good Samaritan Hospital
Courtesy Staff, 1950-51
Associate Attending Obstetrician & Gynecologist, 1951-56
Attending Obstetrician & Gynecologist, 1956
Director Residency Training in Ob-Gyn, 1963-66
Director Department of Obstetrics and Gynecology, 1966—
Christ Hospital - Courtesy Staff, 1951-59
Associate Attending Obstetrician & Gynecologist, 1959-70
Consulting Staff, 1971—
Bethesda Hospital - Courtesy Staff, 1951-56
Associate Attending, 1956-66

Professional Societies:
AMA. Ohio State Medical Association, Cincinnati Academy of Medicine - 1950
Cincinnati Obstetrical and Gynecological Society - 1953
Founding Fellow, American College of Obstetricians and Gynecologists, 1952
Fellow, American College of Surgeons, 1954
Central Association of Obstetricians and Gynecologists, 1955

Offices:
Treasurer, Cincinnati Obstetrical and Gynecological Society, 1959
President, Cincinnati Obstetrical and Gynecological Society, 1962
Executive Committee Central Association Obst. & Gynec., 1964-67
Vice-President, Central Association Obst. & Gynec., 1968-69
Executive Board, Good Samaritan Hospital - 1962-65 & 1966—
President, Good Samaritan Family Life Clinic - 1964-74
Treasurer, American College of Obstetricians and Gynecologists, 1971-77
Executive Board, American College of Obstetricians and Gynecologists, 1971-79
Executive Committee, American College of Obstetricians & Gynecologists, 1971-79
President, American College of Obstetricians and Gynecologists, 1977-78

Major Councils and Committees:
Chairman, Program Committee, ACOG, District V - 1957
Chairman, Program Committee, Central Association of Obstetricians and Gynecologists - 1965
Chairman, Program Committee, ACS, Ohio Section - 1969
Committee on Finance, ACOG - 1956-72, Chairman, 1965-70
Committee on Professional Standards, ACOG - 1970—, Chairman, 1971-75; Editor, *Standards for Obstetric & Gynecologic Services,* 1974
Committee on Biomedical Ethics, ACOG - 1974-77
Committee of Maternal and Child Care, AMA-1974-77, Chairman, 1976-77
Council on Scientific Affairs, AMA 1976-83
Chairman, Committee on Technology Assessment 1980-82

Council of Medical Specialty Societies, 1978-82
Chairman, Committee on Health Care Delivery
Committee on Graduate Medical Education
Committee on Interspecialty Cooperation
Health Care Commission, ACOG - 1979-82
American Board of Medical Specialties, 1979-82
Chairman, Interdisciplinary Mammography Conference, (NCI, ACP, ACR, ACOG, ACS, AMA, AAFP, CAP, AC Soc.) 1978
Panel on Alphafetoprotein Screening, AMA 1980
Health Policy Agenda, (AMA and 150 specialty and allied health groups) 1983—
Chairman, Medical Science Work Group
Steering Committee

Federal and Industrial:

DHEW, National Center for Health Statistics, Technical Consultant Panel, Revision of U.S. Standard Certificates 1975
Chairman, Technical Advisory Committee, AMA/DHEW, Surgical Criteria Project, Contract No. HCFA-500-78-0011
Consultant, Proctor & Gamble (Paper Products Division) 1980—
Panel On Reproductive Hazards in the Workplace, AMA and Industrial Physicians, 1982—

Community Activities:

Hospital Liaison Committee, Cincinnati Hospital Council - 1967
Cincinnati Health and Welfare Council - 1965
Budget Committee, Cincinnati Community Chest - 1959-61
Board of Trustees, Cincinnati Music Festival Association - 1964-69
Board of Trustees, Academy of the Sacred Heart - 1960-66
Board of Lay Advisors, St. Xavier High School - 1968-72

Board of Governors, Xavier University Alumni Association - 1960-63
Mens Symphony Committee - 1965-69
Executive Committee, Navy League Cincinnati Council - 1960-64